

SECTION V - TREATMENT DATA

First Course of Treatment - General Instructions

First course of treatment (or therapy) includes all methods of treatment recorded by the managing physician(s) in the treatment plan *and administered before disease progression or recurrence*. This may include the treatment choice "no therapy" (as when a patient refuses treatment, someone refuses for the patient, the patient died before treatment could begin, or a medical recommendation of "no treatment" was made). In general, only code treatments *actually administered* to the patient (the refusal of some types of treatment is also coded). The MCR follows COC rules concerning what constitutes first-course treatment.

Treatment Plan

A treatment plan is a statement made by the managing physician(s), documenting how they intend to modify or control the disease. All cancer-directed treatments specified in the treatment plan that are delivered to the patient are part of the first course of therapy. A treatment plan may specify one treatment method or a combination. A single "regimen" may include a combination of concurrent or adjuvant treatments. A recommendation of "no treatment" or "watchful waiting" is also a treatment plan; if cancer-directed treatment begins *after* a planned period of watchful waiting, then this treatment is *subsequent therapy* and it is not reportable to the MCR.

A treatment plan's documentation may be fragmented and is frequently found in several different sources, including the hospital medical record, clinic record, consultation reports and outpatient records. Some information may only be recorded in a physician's office.

Time Periods for All Malignancies Except Leukemias

First course of therapy includes all cancer-directed treatment planned by the physician(s) during or after the first diagnosis of cancer. Planned treatment may include multiple modes of therapy and may encompass intervals of a year or more.

When a treatment plan has been made but is *not available* to you, evaluate the therapy and the time it started. If the therapy is part of an established protocol, or within accepted management guidelines for the disease, consider it to be first-course therapy.

If there is no treatment plan, established protocol, or management guidelines and you cannot consult with a physician, use the following principle: "Initial treatment must begin within four months of the date of initial diagnosis." All other cancer-directed therapy that begins within four months of the date of initial treatment is first course of therapy.

Treatment failure or disease progression may cause the planned first-course therapy to be stopped mid-course. Any treatments administered *after the discontinuation* of first-course therapy are considered *subsequent therapy* (don't record it for the MCR).

TREATMENT DATA cont.

Time Periods for Leukemias Only

First course of therapy includes all cancer-directed treatments planned by the physician(s) during or after the first diagnosis of this leukemia. Record all remission-inducing or remission-maintaining cancer-directed therapy as first-course (including radiation to the brain/CNS). Treatment regimens may include multiple therapy modes, and their administration may encompass a year or more. For example, first-course protocols for some pediatric leukemias may encompass two years or more; the induction, consolidation and maintenance phases of the treatment are all considered first-course.

When a treatment plan has been made but is *not available* to you, evaluate the therapy and the time it started; if the therapy is part of an established protocol or within accepted management guidelines for the leukemia, it is first-course.

If there is no treatment plan, established protocol, or management guidelines and you cannot consult with a physician, use the principle: "Initial treatment must begin within two months of the date of initial diagnosis." All other cancer-directed therapy that begins within two months of the date of initial treatment is first course of therapy.

A patient may relapse after a first remission. All treatment administered after relapse is subsequent therapy (don't record this for the MCR).

Definitions

"Cancer-Directed Treatment" -- Cancer-directed treatment is tumor-directed and is not limited to the primary site. Its purpose is to **modify, control, remove or destroy primary or metastatic cancer tissue**. It may minimize tumor size or delay disease spread. Some types of palliative care may be considered cancer-directed; for example, radiation to help relieve painful bone metastases is not meant to be curative, but it is cancer-directed in that the palliative effect is achieved by destroying cancer cells proliferating in the bone; *it treats the disease* as well as the patient.

"Non Cancer-Directed Treatment" -- These treatments prolong life, ease pain, or prepare a patient for cancer-directed therapy. They are not directed at tumor; they are not meant to reduce tumor size or delay disease spread. Such treatments include diagnostic procedures, procedures done to evaluate disease stage, and supportive care* (treatments designed to relieve symptoms or minimize the cancer's effects). The MCR only collects information on non cancer-directed *surgery* (in the "Diagnostic, Staging or Palliative Procedures" fields).

* For hematopoietic diseases only, supportive care may be coded as "Other Cancer-Directed Therapy". See p. 179 for details.

TREATMENT DATA cont.

TREATMENT DATA ITEMS

Treatment - Summary / Treatment - At This Facility Codes -- Numerical codes are used to describe each treatment modality (surgery, radiation, chemotherapy, etc.). For each modality, there is a field used to code a Summary of the entire first course of treatment, and a field to assign a separate code to that portion of the treatment administered at the reporting hospital.

For the purposes of treatment coding, the office of a physician on the hospital's medical staff should be considered to be an extension of the hospital (i.e., when coding treatment given at the reporting hospital, include treatment administered in the office of a physician on the medical staff if you have information about what procedures were done there).

Treatment - Start Dates -- There is a *start* date field for each modality. Dates should be entered in MMDDCCYY format. If an exact start date is not available, please record an *approximate* date. An estimated date is preferable to an unknown date -- and if you report an approximate date for us, please identify this in the appropriate Narrative field.

Example: You can only estimate that radiation began in early March 2001. Enter **03072001** as an approximate start date for Radiation Therapy, and include in the Radiation Narrative a phrase like "early March start date estimated".

If the treatment was administered in courses (as in a radiation series) or included different procedures (e.g., an excisional biopsy and a resection), enter the date of the first procedure.

For any type of treatment that is *not known to have been given*, fill the date field with zeroes. (For example, if the "Chemotherapy -- Summary" and "Chemotherapy -- At This Facility" fields are coded **0** because the first course of treatment included no Chemotherapy, then "Chemotherapy -- Date Started" should be coded **00000000**.) For autopsy-only cases, the date fields should also be zero-filled. Do *not* leave any treatment date field empty.

If, however, a type of treatment *is known to have been given*, but its start date is not known, enter nines *if you cannot estimate* when it began; if the month or year can at least be estimated, however, it is important to enter this (such as **99992001**).

Treatment Text -- There is a Narrative field for each treatment modality. These fields should be used to describe first course of treatment as concisely and specifically as possible. If more than one procedure was performed, list each in chronological order, including dates and the place where each procedure occurred. A text field may be left blank when that particular treatment modality was not provided; but, if no cancer-directed Surgery was performed, please record the reason in the "Surgery -- Narrative" field (for example, "mid-June patient refused recommended lobectomy"). Use standard abbreviations and be aware of the maximum number of characters which can fit into each text field.

TREATMENT DATA cont.

Date of First-Course Treatment -- COC

NAACCR Version 9.1 field Date of 1st Crs Rx--COC, Item 1270, columns 593-600

This field records the beginning of first course of cancer-directed therapy for the case being reported (using the COC's and MCR's definition of what constitutes the "first course"). Use the MMDDCCYY format.

This date should be either:

- the reported start date for one of the six treatment modalities for a patient who received first-course treatment

or, if the patient received no first-course cancer-directed therapy,

- the date on which a decision was made to not treat the patient (including a date of refusal made by the patient or on the patient's behalf, or a decision to follow "watchful waiting"). If you do not have exact information about when the decision to not treat was made, please estimate this date. Only use the unknown date codes (**99**) when absolutely necessary.

For many cancer patients, the initial cancer-directed therapy is an excisional biopsy. This field will then contain the date that also appears in the "Surgery -- Date Started" field.

For autopsy-only cases, fill in the date of death (Date of Last Contact) here.

The dates of Diagnostic/Staging/Palliative Procedures (such as incisional biopsies or endoscopic exams) should *not* be included in this field. It is seldom appropriate to record the Date of Diagnosis in this field, unless a case was deemed inoperable/untreatable when it was first diagnosed.

TREATMENT DATA cont.

DIAGNOSTIC, STAGING, OR PALLIATIVE SURGICAL PROCEDURES

Surgical procedures done to diagnose or stage disease (exploratory) or solely for relief of symptoms (palliative) are Diagnostic/Staging/Palliative Procedures. They include the following:

- Biopsy, incisional (a biopsy leaving gross residual disease)
(An *excisional* biopsy is cancer-directed Surgery. A biopsy leaving only microscopic residual disease or no residual disease should be considered excisional.)
- Biopsy, NOS
(Unless otherwise specified, if the specimen size is ≤ 1 cm, assume the biopsy to have been *incisional*, and report it as a Diagnostic/Staging/Palliative Procedure.)
- Dilation and curettage for *invasive* cervical cancer
- Dilation and curettage for invasive or *in situ* cancers of the corpus uteri, including choriocarcinoma
- Removal of fluid (paracentesis or thoracentesis), even if cancer cells are present
- Surgery in which tumor tissue is not intentionally removed

Examples:

- bypass surgery -- colostomy, esophagostomy, gastrostomy, nephrostomy, tracheostomy, urethrostomy
- exploratory surgery -- celiotomy, cystotomy, gastrotomy, laparotomy, nephrotomy, thoracotomy
- Removal of non-cancerous endocrine gland(s)
(but the removal of testes, adrenals or pituitary is Endocrine Surgery for prostate primaries, and should be reported under Hormone Therapy)
- Surgery to relieve pain (e.g., chordotomy)
- Transurethral resection (TUR) without removal of tumor tissue

Brushings, washings, aspiration of cells and hematologic findings (peripheral blood smears) are not surgical procedures. Do not code these for the MCR.

TREATMENT DATA cont.

The codes for Diagnostic/Staging/Palliative Procedures are not site-specific:

no Diagnostic, Staging, or Palliative surgery done	00
incisional biopsy, needle biopsy, or aspiration biopsy of <i>other</i> than the primary site, leaving gross residual disease*	01
incisional biopsy, needle biopsy, or aspiration biopsy of the <i>primary</i> site, leaving gross residual disease**	02
exploratory surgery ONLY (no biopsy)	03
bypass surgery or ___ostomy ONLY (no biopsy)	04
exploratory surgery <u>plus</u> incisional/needle biopsy of the primary site or other sites	05
bypass surgery <u>plus</u> incisional/needle biopsy of the primary site or other sites; ___ostomy <u>plus</u> incisional/needle biopsy of the primary site or other sites	06
Diagnostic/Staging/Palliative Procedure(s), NOS	07
unknown if any Diagnostic/Staging/Palliative Procedure was done	09

* If there is only microscopic residual disease or no residual disease, then consider this to be an excisional biopsy of a non-primary site (cancer-directed Surgery) and code this under Surgery of Other Regional Sites, Distant Sites or Distant Lymph Nodes.

** If there is only microscopic residual disease or no residual disease, then consider this to be an excisional biopsy of the primary site and code it under Surgery of Primary Site.

The code priorities for the Diagnostic/Staging/Palliative Procedures fields are:

- codes **01** - **07** have priority over **09**;
- codes **01** - **06** have priority over **07**;
- within **01** - **06**, the higher number has priority.

Diagnostic/Staging/Palliative Procedures -- Summary

NAACCR Version 9.1 field "Rx Summ--Dx/Stg/Pall Proc", Item 1350, columns 623-624

Using the code table above, report the Diagnostic/Staging/Palliative Procedures performed during first course of treatment. Enter the best code to represent *all* such procedures performed -- include procedures done at the reporting facility plus all known procedures performed elsewhere. If multiple procedures were performed, follow the code priority rules above, and list these procedures, with their dates and places, in the "Surgery -- Narrative" field.

TREATMENT DATA cont.

Diagnostic/Staging/Palliative Procedures -- At This Facility

NAACCR Version 9.1 field "Rx Hosp--Dx/Stg/Pall Proc", Item 740, columns 356-357

Using the code table on the previous page, enter the code for just the Diagnostic/Staging/Palliative Procedures performed at the reporting facility (including any done in the office of a staff physician, if the information is available to you). If multiple procedures were performed, follow the code priorities listed under the code table, and be sure that all the procedures, with their dates, are included in the "Surgery -- Narrative" field.

Diagnostic/Staging/Palliative Procedures -- Date Started

NAACCR Version 9.1 field "Rx Date--Dx/Stg/Pall Proc", Item 1280, columns 601-608

See the general instructions for treatment date fields on page 151. When multiple procedures were performed, record the date of the first procedure done.

NOTE: There is *not* a separate Narrative field for Diagnostic/Staging/Palliative Procedures. The field "Surgery -- Narrative" records both cancer-directed Surgery and Diagnostic/Staging/Palliative surgical Procedures.

TREATMENT DATA cont.

SURGERY (Cancer-Directed)

The COC has replaced the phrases "non cancer-directed surgery" and "cancer-directed surgery" with the phrases "diagnostic, staging, and palliative procedures" and just plain "surgery" without altering the associated fields or data standards. The MCR likes the clarity of the older terms so we have not abandoned them entirely in this Manual. It is especially important to remember that surgical procedures are not limited to the COC's "surgery" fields -- the "diagnostic, staging, palliative procedures" are also considered surgical procedures.

Cancer-directed Surgery is tumor-directed. Its purpose is to modify, control, remove or destroy cancer tissue.

Surgical procedures performed solely for the purpose of establishing a diagnosis or stage of disease or for symptom relief are not cancer-directed. Record such procedures as Diagnostic/Staging/Palliative Procedures.

Excisional biopsies *are* cancer-directed Surgery. When a surgeon states that the procedure was an excisional biopsy or that all gross tumor was removed, code it as excisional even if the pathology report shows microscopic involvement of the margins. If there is no statement that the initial biopsy was "excisional", yet no residual tumor was found at a later resection, assume that the biopsy *was* excisional. If an excisional biopsy is followed by a "re-excision" or "wide excision" during the first course of treatment, include the later information in coding the cancer-directed Surgery. Record the date of an excisional biopsy as the first date of cancer-directed Surgery, whether followed by further definitive surgery or not, and whether or not residual tumor was found in a later resection.

There are four types of cancer-directed Surgery codes collected by the MCR: "Surgery of the Primary Site" (codes in Appendix D); "Scope of Regional Lymph Node Surgery" (codes in Appendix D); "Number of Regional Lymph Nodes Removed"; and "Surgery of Other Regional Sites, Distant Sites, or Distant Lymph Nodes" (codes in Appendix D). The codes in Appendix D are site-specific. Histology is irrelevant when choosing the surgery coding scheme; for example, surgeries for nodal lymphomas are coded using the "Spleen and Lymph Nodes" scheme, while a stomach lymphoma would be coded according to the "Stomach" scheme. Codes for reconstructive/restorative surgical procedures ("Reconstruction -- First Course") are also site-specific and are also in Appendix D.

TREATMENT DATA cont.

Surgery of Primary Site

Only record surgeries of the *primary site* in this section. Surgery to remove regional tissues or organs is coded in this section only if these tissues/organs are removed *along with* the primary site as part of a specified code definition (in Appendix D) or in an 'en bloc resection'. (An en bloc resection is the removal of multiple organs in one piece at one time.)

Example: When a patient has a modified radical mastectomy, since the breast and axillary contents are removed in one piece (en bloc), "Surgery of Primary Site" is coded as a modified radical mastectomy (**50**), even if pathology finds no nodes in the specimen. (See the codes in Appendix D, page D-46.)

Record a non en bloc resection of a secondary or metastatic site in the field "Surgery of Other Regional Sites, Distant Sites or Distant Lymph Nodes".

If no primary site surgical procedure was done, use code **00**.

A biopsy that removes all gross tumor or leaves only microscopically involved margins should be coded here as excisional. A biopsy that is called *excisional* by the performing surgeon should be coded as such, even if residual disease is indicated when the margins are examined.

The operative report title alone may not include enough information to help you assign the best surgery code. Use all of the operative report text and the pathology report to confirm the procedure that was truly done. Use the information from the pathology report when an operative report is unclear or is inconsistent, unless the pathology report states that an accurate accounting of organs removed cannot be given (e.g., tumor encasement, crush artifact, etc.).

The general priority scheme for the "Surgery of Primary Site" codes in Appendix D is as follows:

codes **10 - 90** have priority over **99**;

codes **10 - 84** have priority over **90** and **99**;

codes **10 - 79** have priority over codes **80, 90** and **99** (when code **80** is for a site-specific surgery, NOS)

The range of codes **00 - 84** are generally hierarchical -- as the code numbers ascend, the procedures represented become more invasive and/or radical. If more than one code describes the procedure, use the numerically higher code.

TREATMENT DATA cont.

If the patient has *multiple* cancer-directed surgeries of the *same* primary site, code the most invasive, definitive surgery (numerically highest code); if the coding scheme allows, assign a specific code that describes the total result of all first-course Primary Site Surgeries.

Examples: A patient has a colonoscopy with removal of a polyp in the sigmoid colon (see the codes in Appendix D, page D-16, code **26**). A week later the patient has a hemicolectomy ("Surgery of Primary Site" code **40**). Record the hemicolectomy code because it is the most invasive, definitive surgery and has the numerically higher code.

Patient has a lung wedge resection (code **21**); later in first-course surgery, the remainder of that lobe is removed. Code a total lobectomy (**31**).

A lymph node dissection during first course of therapy that is performed separately from a Primary Site Surgery may be combined into a single code that represents both surgeries when the coding scheme allows. For example, a simple mastectomy (code **40**) followed by the separate removal of the axillary nodes could be coded as a modified radical mastectomy (**50**).

Code the appropriate surgery for each site when *multiple primaries* are excised at the same time.

Examples: A total abdominal hysterectomy was performed for a patient who had cancer of the cervix and of the endometrium. Code a total abdominal hysterectomy for each of the two primaries.

Patient has a total colectomy for multiple primary cancers originating in several segments of the colon. Code a total colectomy for each primary.

In the "Surgery -- Narrative" field, though, record *all* known primary site surgical procedures done at the reporting institution **and** at other institutions.

Example: "1/15/2001 colonoscopy & polypectomy done here; 1/18/01 hemicolectomy at Hospital B".

Surgery of Primary Site -- Summary

NAACCR Version 9.1 field "Rx Summ--Surg Prim Site", Item 1290, columns 609-610

Using the codes for the appropriate primary site in Appendix D, enter the best code for all Surgery of Primary Site performed as part of first course of treatment. This includes treatment given at the reporting facility, plus all *known* treatment given elsewhere. If multiple procedures were done, code the procedure having the highest code number, and list *all* procedures, with their dates and places of performance, in the "Surgery -- Narrative" field.

TREATMENT DATA cont.

Surgery of Primary Site -- At This Facility

NAACCR Version 9.1 field "Rx Hosp--Surg Prim Site", Item 670, columns 341-342

Using the codes in Appendix D, enter the code for the Surgery of the Primary Site performed only at the reporting facility. If multiple primary site procedures were performed at your facility, enter the code for the procedure having the highest code number, and be sure that the "Surgery -- Narrative" field includes all the procedures, with their dates. Include procedures performed in a staff physician's office if you have this information.

Surgery -- Date Started

NAACCR Version 9.1 field "Rx Date--Surgery", Item 1200, columns 537-544

See the general instructions on page 151 for treatment date fields. Record the date of an excisional biopsy here, whether followed by further definitive surgery or not, and whether or not residual tumor was found later. Record the earliest date of all coded cancer-directed surgeries (of primary site, regional nodes, other regional sites, distant sites, distant nodes) -- *not* just surgery of the primary site.

Surgery -- Narrative

NAACCR Version 9.1 field "Rx Text--Surgery", Item 2610, columns 3747-3896

This field holds up to 150 characters only, yet it often has to include lots of important information. Continue this important narrative in an empty treatment text field or in the "Comments/Narrative Remarks" field if necessary. See the general instructions on page 151 for treatment text fields. Include all known Diagnostic/Staging/Palliative Procedures and Surgery (of primary site, regional nodes, regional sites, distant sites, distant nodes) performed in chronological order, with dates and places (where the surgeries were done). Include reconstructive procedures when possible. If no cancer-directed Surgery was done, give a reason here if known to you (for example, "5/15/2001 pt refused surgery recommended at Hospital B" or "1/18/2001 sigmoidoscopy done here; 1/20/01 excision of rectal mass at Hospl B; 1/25/01 liver mets ablation at Hospl C"). Be specific about describing any Diagnostic/Staging/Palliative Procedures; do not enter vague text like "bx of other than primary site" -- tell us what site was actually biopsied. If the Surgery Date reported is an estimate, note that here.

TREATMENT DATA cont.

Scope of Regional Lymph Node Surgery

For most primary sites, these fields define the removal of regional lymph nodes. This refers to the regional lymph node removed that is farthest from the primary site, regardless of its involvement with disease. There is no minimum number of nodes that must be removed. If at least one regional lymph node was removed, the code for this field must be in the range **1-5**. If a regional lymph node was aspirated or biopsied, code "regional lymph node(s) removed, NOS" (**1**).

For head and neck sites, this field describes neck dissections. Codes **2-5** indicate only that a neck dissection was done; they do not imply that nodes were found during the pathologic examination of the specimen. Code a neck dissection here *even if no nodes* were found.

The codes are hierarchical. If more than one procedure was performed, or if more than one code applies, code the procedure that is numerically higher.

Examples: A patient with a head and neck primary has a lymph node biopsy (code **1**), followed by a limited neck dissection (**3**). Code the limited neck dissection.

If a patient has a *modified* radical neck dissection, record code **4** rather than the more generic "neck dissection, NOS" (**2**).

For most primary sites in Appendix D, a list identifies the specific nodes which are regional. (For some primary sites, each subsite has different regional nodes.) Any other nodes are considered *distant* and are coded in "Surgery of Other Regional Sites, Distant Sites or Distant Lymph Nodes".

If no cancer-directed surgical procedure was performed, enter code **0**.

TREATMENT DATA cont.

Scope of Regional Lymph Node Surgery -- Summary

NAACCR Version 9.1 field "Rx Summ--Scope Reg LN Sur", Item 1292, column 611

Using the codes for the appropriate primary site in Appendix D, report the Scope of Regional Lymph Node Surgery done at your facility and elsewhere if known to you.

Scope of Regional Lymph Node Surgery -- At This Facility

NAACCR Version 9.1 field "Rx Hosp--Scope Reg LN Sur", Item 672, column 343

Using the codes in Appendix D, code just the Scope of Regional Lymph Node Surgery done at your facility. Include procedures done in a staff physician's office (if available).

Number of Regional Lymph Nodes Removed

Record the number of regional nodes microscopically examined and documented in the pathology report from only the surgical procedure(s) coded in the "Surgery of Primary Site" fields. Do not add numbers of nodes removed at different surgical events.

If *no* regional lymph nodes are identified in the pathology report, code **00** here, even if the surgical procedure usually includes a lymph node dissection (e.g., modified radical mastectomy), or if the operative report documents the removal of nodes.

Note: Because these fields are *not* cumulative and not affected by timing, they do not duplicate the field "Regional Nodes Examined" (which describes *all* regional nodes removed during the entire first course of treatment). Do not automatically copy one field to another. (See pages 142-143 for the field "Regional Nodes Examined".)

For all cases with a primary site of lymph nodes (C77._), fill the Number of Regional Lymph Nodes Removed fields with code **99**. Do *not* code *all* lymphomas this way -- just those with lymph node primary sites. Also use code **99** for leukemias.

TREATMENT DATA cont.

For all cases with an unknown primary site (C80.9), fill the Number of Regional Lymph Nodes Removed fields with code **99**.

There are **NO** regional lymph nodes for the brain (C71.~, C70.0). Enter code **99** for all cases with a brain/cerebral meninges primary site code.

Codes for all cases *except* leukemias and those with primary sites Brain, Cerebral Meninges, Lymph Nodes, and Unknown Primary Site follow:

Number of Regional Lymph Nodes Removed	Code
None removed	00
One removed	01
Two removed	02
.....
Ninety <u>or more</u> removed	90
Regional lymph node removal was documented as a <u>sampling</u> and the exact number of lymph nodes was unknown/not stated.	96
No regional lymph node(s) were actually removed, but a regional lymph node <u>aspiration</u> was performed.	95
Regional lymph node removal was documented as a <u>dissection</u> and the exact number of lymph nodes was unknown/not stated.	97
Regional lymph nodes were surgically removed, but the number was unknown/not stated and the removal was <u>not</u> documented as a "sampling" or "dissection".	98
Unknown number removed; number removed not stated; death certificate only	99

Number of Regional Lymph Nodes Removed -- Summary

NAACCR Version 9.1 field "Rx Summ--Reg LN Examined", Item 1296, columns 613-614

Using the codes above, record the Number of Regional Lymph Nodes Removed at your facility and elsewhere for the surgical procedure coded in "Surgery of Primary Site -- Summary".

Number of Regional Lymph Nodes Removed -- At This Facility

NAACCR Version 9.1 field "Rx Hosp--Reg LN Removed", Item 676, columns 345-346

Using the codes above, record just the Number of Regional Lymph Nodes Removed at your facility for the procedure coded in "Surgery of Primary Site -- At This Facility".

TREATMENT DATA cont.

Surgery of Other Regional Sites, Distant Sites or Distant Lymph Nodes

These fields describe the *separate* (not en bloc with the primary) removal of tissue(s) or organ(s) *other than* the primary tumor/organ of origin. If regional/distant tissues/organs were removed in continuity with the primary tumor (en bloc), their removal is reported under Surgery of the Primary Site rather than here. Include the removal of any non-primary tissue that was removed because the surgeon *suspected* malignant involvement, even if the pathology was negative. Do not code the *incidental* removal of tissue (i.e., removed for reasons other than suspected malignancy).

Examples: During a colon resection, the surgeon noted cholelithiasis and removed the gallbladder. The gallbladder's removal is *incidental* and should not be coded in any field.

In the above example, if the gallbladder had been removed separately because it was suspicious for cancer involvement, its removal would be coded in this field *regardless* of what the pathology report revealed about the specimen's actual involvement.

During a rectal resection, the surgeon destroyed a spot on the liver that was presumed to be cancerous. Code in this field the ablation of a single liver metastasis even though there was no pathologic verification that the tissue destroyed was indeed cancer.

Surgery of Other Regional Sites, Distant Sites or Distant Lymph Nodes -- Summary
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NAACCR Version 9.1 field "Rx Summ--Surg Oth Reg/Dis", Item 1294, column 612

Using the codes for the appropriate primary site in Appendix D, report the Surgery of Other Regional Sites, Distant Sites or Distant Lymph Nodes performed at your facility and elsewhere (if known to you).

Codes **1 - 8** have priority over code **9**.

Surgery of Other Regional Sites, Distant Sites, or Distant Lymph Nodes -- At This Facility
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NAACCR Version 9.1 field "Rx Hosp--Surg Oth Reg/Dis", Item 674, column 344

Using the codes in Appendix D, report just the Surgery of Other Regional Sites, Distant Sites or Distant Lymph Nodes performed at your facility as part of first course of therapy. Include procedures performed in a staff physician's office if known to you.

Codes **1 - 8** have priority over code **9**.

TREATMENT DATA cont.

Reconstruction -- First Course

NAACCR Version 9.1 field "Rx Summ--Reconstruct 1st", Item 1330, column 621

This field codes surgical procedures that improve the shape, appearance or function of body structures that are missing, defective, damaged or misshapen by cancer *or* its treatment.

This field is limited to procedures started during the first course of therapy. Some reconstructive procedures involve several events; only code these here if the first event occurred during the first course of treatment. The MCR does not collect data on procedures which *started* after the first course of treatment's completion (or *delayed* reconstruction).

Use the codes for the appropriate primary site in Appendix D. Code *only* those procedures specifically listed for each site. Codes **1 - 8** have priority over code **9**.

TREATMENT DATA cont.

Reason For No Surgery

NAACCR Version 9.1 Item 1340, column 622

For *all* cancers, this field records if cancer-directed Surgery was done; and if it was *not* done, it records a reason *why* it was not done. This includes all first-course cancer-directed Surgery of the primary site, regional lymph nodes, other regional sites, distant sites or distant lymph nodes. Include all Surgery performed as part of first course of therapy that is known to you (i.e., what is coded in the *summary* Surgery fields -- not just what was done at your facility).

Record a reason why cancer-directed Surgery was not performed for this case; or, if it was performed, enter 0.

Enter the most applicable number from the following codes:

Surgery was performed. (At least one of the Surgery summary fields must be coded without 00 or 0 .)	0
Surgery was not recommended. (includes inoperable cancer, widespread cancer, and conditions not treated surgically, such as leukemia)	1
Surgery was contraindicated because of other conditions; also autopsy-only cases (includes advanced age and the presence of other diseases, such as heart disease, that would contraindicate surgery)	2
The reason for no Surgery is unknown. (Cancer-directed surgery would have been the treatment of choice, but it was not performed, and a reason is not given.)	6
patient/guardian refused Surgery (Cancer-directed surgery was the treatment of choice and was recommended by the physician, but the patient, a family member, or a guardian refused the surgery.)	7
Surgery was recommended, but it's not known if it was performed. (Cancer-directed surgery was recommended by a physician, but no follow-up information is available to confirm if the surgery was performed.)	8
unknown if Surgery recommended or performed; (also death certificate-only cases) (No confirmation if Surgery was recommended or performed.)	9

TREATMENT DATA cont.

RADIATION THERAPY

Code the type of Radiation Therapy that the patient received. This field records radiation administered to the primary site or any metastatic site for *curative, palliative* or *prophylactic* intent, remembering that the treatment must be cancer-directed. For example, radiation administered to alleviate the pain caused by bony metastases is not meant to cure the cancer, but it is still cancer-directed therapy because it kills cancer cells in the body. For primary lung cancers and leukemia cases, include radiation given to the brain and CNS in this field. Record all procedures that are part of the first course of therapy.

Do not include radiation for hormonal effect, such as irradiation of non-cancerous endocrine glands. Do not include irradiation of the male breast to prevent gynecomastia.

Types of Radiation

The primary types of Radiation Therapy include the external administration of radioactive beams, implantation of radioactive material, and the internal administration of radioisotopes by means other than implantation. Radioactive materials include the following:

Au ¹⁹⁸	gold	P ³²	phosphorus
Co ⁶⁰	cobalt	Pb ²¹⁰	lead
CrO ₄ P	chromic phosphate	Ra ²²⁶	radium
Cr ³² PO ₄	phosphocol	Rn ²²²	radon
Cs	cesium	Ru ¹⁰⁶	ruthenium
I ¹²⁵ and I ¹³¹	iodine	Sr ⁸⁹ and Sr ⁹⁰	strontium
Ir ¹⁹²	iridium	Y ⁹⁰	yttrium

Beam (Teletherapy) (code 1) -- The source of radiation is outside the patient, as in a cobalt machine or linear accelerator. Examples of beam radiation include the following:

Betatron	Linear accelerator (LINAC)
Brachytron	MeV
Cobalt	Neutron beam
Cyclotron	Spray radiation
Grenz ray	Stereotactic radiosurgery (gamma knife, proton beam)
Helium ion or other heavy particle beam	X-ray

Radioactive Implants (code 2) -- Radioactive materials administered by interstitial implants, molds, seeds, needles or intracavitary applicators, including brachytherapy. (Heyman capsules, Fletcher suit, and Fletcher after-loader are methods of isotope application. Interpret these terms as radioactive implants.)

TREATMENT DATA cont.

Other Internal Radiation (code **3**) -- Record the name or chemical symbol and method of administration of any radioactive material given orally, intracavitarily, or by intravenous injection. (I^{131} -labeled immunoglobulin is coded both as a radioisotope and Immunotherapy.)

Use the following codes for Radiation Therapy:

no Radiation Therapy given	0
beam radiation (X-ray, cobalt, linear accelerator, neutron beam, spray radiation, intra-operative radiation and stereotactic radiosurgery, gamma knife and proton beam)	1
radioactive implants (brachytherapy, interstitial implants, molds, seeds, needles or intracavitary applicators of radioactive materials -- cesium, radioactive gold, radium, radon)	2
radioisotopes (internal use of radioactive isotopes, such as iodine-131, phosphorus-32, strontium-89, strontium-90)	3
combination(s) of beam radiation with radioactive implants or with radioisotopes given internally (combination of 1 with 2 and/or 3)	4
Radiation Therapy, NOS (method or source not specified)	5
unknown if Radiation Therapy administered	9

Note: Codes 7 and 8 are no longer used for diagnoses as of January 1, 1996. If a patient/guardian refused Radiation Therapy, use code **0**. If Radiation Therapy was recommended but you do not know if it was ever given, also use code **0**.

Radiation Therapy -- Summary

NAACCR Version 9.1 field "Rx Summ--Radiation", Item 1360, column 625

Using the code table above, code all the first course of treatment Radiation Therapy received by the patient at your facility *and* elsewhere (if known to you).

Radiation Therapy -- At This Facility

NAACCR Version 9.1 field "Rx Hosp--Radiation", Item 690, column 351

Using the code table above, code just the Radiation Therapy administered at your facility. Include treatment administered in the office of a physician on your medical staff (if recorded in your facility's medical record).

TREATMENT DATA cont.

Radiation Therapy -- Date Started

NAACCR Version 9.1 field "Rx Date--Radiation", Item 1210, columns 545-552

See the Treatment Date instructions on page 151.

Radiation Therapy -- Narrative

NAACCR Version 9.1 field "Rx Text--Radiation (Beam)", **Item 2620**, columns 3897-4046

This field holds up to 150 characters. See the Treatment Text instructions on page 151. Although this NAACCR field is meant to contain only information on beam Radiation Therapy (code **1**), please note that the MCR does *not* collect the companion field "Rx Text--Radiation Other" (NAACCR Item 2630) where any nonbeam Radiation Therapy would be described. Please describe all types of Radiation Therapy given to the patient in Item 2620 for the MCR. For your own purposes, you may also separately describe nonbeam radiation in Item 2630, but remember that anything you record there will not be seen by the MCR. If we see any type of Radiation coded that is not documented in Item 2620, we may have to call you to clarify the apparent discrepancy. If the Radiation Date reported is an estimate, note that here.

Radiation / Surgery Sequence

NAACCR Version 9.1 field "Rx Summ--Surg/Rad Seq", Item 1380, column 627

This field defines the order in which first-course Radiation Therapy and cancer-directed Surgery were delivered. This includes all first-course Radiation and Surgery (as coded in the *summary* therapy fields) rather than just treatment given at your facility. Enter codes in the range **2-9** if the patient had both Radiation and Surgery during first-course treatment. Diagnostic/Staging/Palliative Procedures (e.g., incisional biopsy, exploratory surgery) do not qualify, but all types of cancer-directed Surgery (including surgery of primary site, regional lymph nodes, other regional sites, distant sites or distant lymph nodes) are included.

Code Radiation / Surgery Sequence as follows:

no Radiation Therapy and/or cancer-directed Surgery	0
Radiation Therapy <u>before</u> cancer-directed Surgery	2
Radiation Therapy <u>after</u> cancer-directed Surgery	3
Radiation Therapy both <u>before and after</u> cancer-directed Surgery	4
intraoperative Radiation Therapy alone	5
intraoperative Radiation Therapy <u>with other</u> Radiation Therapy given before or after cancer-directed Surgery	6
sequence unknown, but <u>both</u> Radiation Therapy and cancer-directed Surgery were administered	9

TREATMENT DATA cont.

CHEMOTHERAPY

Chemotherapeutic agents are anticancer drugs that inhibit the reproduction of cancer cells by interfering with DNA synthesis and mitosis, causing the cells to die. Chemotherapy may be administered by intravenous infusion or given orally. They may also be topical, intrathecal, intracavitary or intra-arterial. Methods of administration are not coded for the MCR.

Chemotherapy agents may be administered singly or in combination regimens of two or more chemotherapy drugs. The drugs are frequently given in combinations referred to by acronyms or protocols. You may use standard acronyms and abbreviations, but do not enter protocol numbers alone. Two or more single agents given at separate times during first course of therapy are considered to be a *combination* regimen. See the *SEER Self Instructional Manual for Tumor Registrars: Book 8, 3rd Ed.* (1993) for a list of the standard acronyms used for combination regimens (pages 29-31).

Chemotherapy is often administered in treatment cycles with the time span of each cycle varying. Chemotherapy may be administered for several weeks or years. For the MCR, only record Chemotherapy that is part of first course of treatment.

Also record Chemotherapy as cancer-directed therapy when it is delivered *concurrently* or as *adjuvant* or *neo-adjuvant* treatment. Concurrent chemotherapeutic agents are used in combination with other modes of therapy (surgery, radiation, etc.) to treat cancer. In adjuvant therapy, when other methods have already destroyed clinically detectable cancer cells, Chemotherapy is given to prevent or delay a recurrence by destroying micrometastases (undetected cancer cells). Neo-adjuvant therapy is given before Surgery or Radiation Therapy to help reduce the size (bulk) of a tumor.

TREATMENT DATA cont.

Chemotherapy may be divided into the following four groups:

Group I: Alkylating Agents

Busulfan (Myleran)	DTIC (Dacarbazine)
Carmustine (Lomustine)	Mechlorethamine (Mustargen)
Chlorambucil (Leukeran)	Phenylalanine mustard (Melphalan)
Cyclophosphamide (Cytosan)	Triethylene-thiophosphoramide (Thio-TEPA)

Group II: Antimetabolites

Folic acid analogs:	Methotrexate (Amethopterin, MTX)
Pyrimidine analogs:	5-Fluorouracil (5-FU)
Purine analogs:	6-Mercaptopurine (6-MP)

Group III: Natural Products

Antitumor antibiotics:	Bleomycin (Blenoxane)
	Dactinomycin (Actinomycin D)
	Daunorubicin (Daunomycin)
	Doxorubicin (Adriamycin)
	Mitomycin C (Mutamycin)
Vinca (plant) alkaloids:	Vinblastine (VBL, Velban)
	Vincristine (VCR, Oncovin)
Enzymes:	L-Asparaginase (Elspar)

Group IV: Miscellaneous Agents

Cis-diammine dichloroplatinum II (Cisplatin)
Hydroxyurea (Hydrea)
Procarbazine (Matulane)

See the *SEER Self Instructional Manual for Tumor Registrars: Book 8, 3rd Ed.* (1993) for a comprehensive list of chemotherapy agents in use at the time of its publication (pages 5-28).

When a patient has an adverse reaction to initial chemotherapy, a physician may change one of the agents being administered. If the replacement drug belongs to the same group (Groups I-IV shown above) as the original drug, there is considered to have been *no change in the regimen* and this is just a continuation of the planned first course of therapy; but if the replacement agent falls into a different group than the original drug, then this is considered a *new regimen* and *subsequent therapy* (i.e., not first-course and not collected by the MCR).

TREATMENT DATA cont.

Note: Leucovorin is an example of an ancillary drug which may be administered in conjunction with chemotherapeutic agents. See pages 35-46 in the *SEER Self Instructional Manual for Tumor Registrars: Book 8, 3rd Ed.* (1993) for a list of ancillary drugs. Ancillary drugs are not coded for the MCR, but they may be recorded in the "Chemotherapy -- Narrative" field.

Example: 5-FU and Leucovorin are both given to a cancer patient as part of the planned first course of therapy. If there are no additional Chemotherapy agents given, the correct Chemotherapy code is **2** ("single agent") -- not **3** ("multiple agents"). Chemotherapy -- Narrative could say "5-FU (+ Leucovorin)".

When Prednisone (a hormone) is given in combination with a chemotherapy agent, the Prednisone is coded as Hormone Therapy and the Chemotherapy agent alone is coded here.

Use the following codes for Chemotherapy:

no Chemotherapy given	0
Chemotherapy, NOS	1
Chemotherapy, single agent	2
Chemotherapy, multiple agents (combination regimen)	3
unknown if chemotherapy recommended or administered	9

Notes: In the range **1-3**, the higher code number has priority.

Codes 7 and 8 are no longer used for diagnoses as of January 1, 1996. If a patient/guardian refused Chemotherapy, use code **0**. If Chemotherapy was recommended but you do not know if it was ever given, also use code **0**.

TREATMENT DATA cont.

Chemotherapy -- Summary

NAACCR Version 9.1 field "Rx Summ--Chemo", Item 1390, column 628

Using the code table on the preceding page, report all the Chemotherapy given to the patient as part of first course of treatment. Include Chemotherapy given at your institution *and* at all others (if known to you).

Chemotherapy -- At This Facility

NAACCR Version 9.1 field "Rx Hosp--Chemo", Item 700, column 352

Using the code table on the preceding page, report just the Chemotherapy administered at your facility as part of first course of treatment. Include treatment delivered in a staff physician's office if this is recorded in your facility's medical record.

Chemotherapy -- Date Started

NAACCR Version 9.1 field "Rx Date--Chemo", Item 1220, columns 553-560

See the Treatment Date instructions on page 151.

Chemotherapy -- Narrative

NAACCR Version 9.1 field "Rx Text--Chemo", Item 2640, columns 4197-4396

This field may contain up to 200 characters. Record the generic or trade names of the Chemotherapy agents used. Include those that are in the investigative or clinical trial phase. See the *SEER Self Instructional Manual for Tumor Registrars: Book 8, 3rd Ed.* (pages 5-31) for a comprehensive list of chemotherapeutic agents and regimens in use at the time of its publication. You may use standard abbreviations and acronyms (such as "5-FU" and "MOPP"), but do not enter protocol numbers alone. See pages 29-31 in *SEER Book 8* for combination regimen standard acronyms. The names of (uncoded) ancillary drugs given along with Chemotherapy agents may also be included here. If the Chemotherapy Date reported is an estimate, note that here.

TREATMENT DATA cont.

HORMONE / STEROID / ENDOCRINE THERAPY

Hormones promote hormonal withdrawal or hormonal interface to alter cancer growth. Hormonal therapy may effect a long-term control of the cancer, but it is not usually used to “cure” the cancer.

Code the type of Hormone Therapy the patient received as part of first course of therapy. Record surgery performed for hormonal effect (such as orchiectomy) and radiation given for hormonal effect.

Hormones and Antihormones

Report cancer-directed treatment with hormones and antihormones for all sites and types of cancer. Report cancer-directed use of adrenocorticotrophic hormones for the treatment of leukemias, lymphomas, multiple myeloma, and breast and prostate cancers.

Code Prednisone as Hormonal Therapy when it is given in combination with Chemotherapy (e.g., MOPP or COPP) for cancer of *any* site. If administered for other reasons, do *not* code such agents as Hormone Therapy.

Examples:

- A patient with advanced cancer is given Prednisone to stimulate appetite. Do not code this.
- A patient with advanced lung cancer has multiple brain metastases. The physician orders Decadron to reduce edema in the brain and relieve neurological symptoms. This use of Decadron is not coded as Hormone Therapy.

Hormone classifications include the following:

adrenocorticosteroids (Prednisone, Decadron)
androgens (Halotestin)
antiestrogens (Tamoxifen, Nolvadex)
estrogens (DES, diethylstilbestrol)
hormone synthesis inhibitors (Elipten, Cytadren)
progestins (Provera, Megace)

For a more complete list of hormonal agents, see the *SEER Self Instructional Manual for Tumor Registrars: Book 8, 3rd Ed.* (1993).

TREATMENT DATA cont.

Thyroid-stimulating hormone (TSH) is normally *replacement* therapy and *not* tumor-directed; however, the administration of thyroid hormone preparations (like Synthroid) following thyroidectomy *is* definitive Hormonal Therapy because the TSH has a dual role in such cases -- as replacement therapy *and* to inhibit cancer recurrence and metastasis. Exogenous dissected thyroid may be used in treatment following a subtotal or total thyroidectomy.

Endocrine Surgery and/or Endocrine Radiation

For reporting purposes, endocrine surgery/radiation (code **2**) is defined as the total removal/irradiation of an endocrine gland (*both* glands or all of one remaining gland in the case of paired glands). Record endocrine surgery and/or radiation for treatment of cancer of the prostate only. Endocrine surgical procedures are as follows:

adrenalectomy
hypophysectomy
orchiectomy

Report any type of radiation directed toward an endocrine gland to affect hormonal balance in these circumstances:

- treatment is for cancer of the prostate;
- both paired glands (testes, adrenals) or all of a remaining gland have/has been irradiated.

If tumor tissue is present in a gland removed in the course of endocrine therapy, record the procedure as cancer-directed Surgery also.

TREATMENT DATA cont.

Use the following codes for Hormone Therapy:

no Hormone Therapy given	0
hormones (including NOS and antihormones)	1
endocrine surgery and/or endocrine radiation therapy (if cancer is of another site)	2
combination of 1 and 2	3
unknown if Hormone Therapy recommended or administered	9

Note: Codes 7 and 8 are no longer used for diagnoses as of January 1, 1996. If a patient/guardian refused Hormone Therapy, use code **0**. If Hormone Therapy was recommended but you do not know if it was ever given, also use code **0**.

Hormone Therapy -- Summary

NAACCR Version 9.1 field "Rx Summ--Hormone", Item 1400, column 629

Using the code table above, report *all* Hormone Therapy performed at your facility *and* elsewhere (if known to you) as part of first course of treatment.

Hormone Therapy -- At This Facility

NAACCR Version 9.1 field "Rx Hosp--Hormone", Item 710, column 353

Using the code table above, report just the first course of treatment Hormone Therapy received at your facility. Include treatment given in a staff physician's office (if known to you).

Hormone Therapy -- Date Started

NAACCR Version 9.1 field "Rx Date--Hormone", Item 1230, columns 561-568

See the Treatment Date instructions on page 151.

Hormone Therapy -- Narrative

NAACCR Version 9.1 field "Rx Text--Hormone", Item 2650, columns 4397-4596

This field may contain up to 200 characters. See the Treatment Text instructions on page 151. If the Hormone Therapy Date reported is an estimate, note that here.

TREATMENT DATA cont.

IMMUNOTHERAPY

Immunotherapy (biological response modifier therapy, BRM) consists of biological or chemical agents that alter the immune system or change a patient's response to tumor cells. Code only Immunotherapy that the patient received as part of first course of therapy.

Immunotherapy agents include:

allogeneic cells	Levamisole
BCG vaccine	MVE-2
bone marrow transplant	Pyran copolymer
C-Parvum	Thymosin
Interferon	vaccine therapy
Interleukin	virus therapy
LAK (lymphokine activated killer) cells	

Refer to the *SEER Self Instructional Manual for Tumor Registrars: Book 8, 3rd Ed.* (1993), pages 55-67, for a complete list of Immunotherapy agents.

Note: *Book 8* lists Epogen (Procrit) and Neupogen as BRM agents, but errata issued by SEER corrected these listings to the "ancillary" drug category. Epogen and Neupogen should not be coded in any First Course of Treatment modality.

Use the following codes for Immunotherapy:

no Immunotherapy given	0
biological response modifier (BRM)	1
bone marrow transplant - autologous	2
bone marrow transplant - allogeneic	3
bone marrow transplant, NOS	4
stem cell transplant	5
combination of 1 and any of 2-5	6
patient/guardian refused Immunotherapy	7
Immunotherapy recommended, but unknown if administered	8
unknown* if Immunotherapy recommended or administered	9

* There is reason to believe that Immunotherapy was recommended or given, but there is no information to confirm this.

TREATMENT DATA cont.

Immunotherapy -- Summary

NAACCR Version 9.1 field "Rx Summ--BRM", Item 1410, column 630

Using the code table on the preceding page, record all first course of therapy Immunotherapy procedures done at your institution, and at all other institutions if known to you.

Immunotherapy -- At This Facility

NAACCR Version 9.1 field "Rx Hosp--BRM", Item 720, column 354

Using the code table on the preceding page, record just the procedures done at your facility. Include treatment given in a staff physician's office (if known to you).

Immunotherapy -- Date Started

NAACCR Version 9.1 field "Rx Date--BRM", Item 1240, columns 569-576

See the Treatment Date instructions on page 151.

Immunotherapy -- Narrative

NAACCR Version 9.1 field "Rx Text--BRM", Item 2660, columns 4597-4696

This field may contain up to 100 characters. See the Treatment Text instructions on page 151. If the Immunotherapy Date reported is an estimate, note that here.

TREATMENT DATA cont.

OTHER CANCER-DIRECTED THERAPY

Other Cancer-Directed Therapy includes treatments given as part of first course of therapy designed to modify or control cancer cells that are not defined in the Surgery, Radiation, Chemotherapy, Hormone Therapy or Immunotherapy fields.

Examples:

- tumor embolization (arterial block) if the surgeon's intent is to kill tumor cells
- any cancer-directed experimental drug that cannot be classified as Chemotherapy, Hormone Therapy or Immunotherapy (code **2**); this includes Thalidomide when used as an anti-angiogenesis agent and Herceptin (a biological response modifier not yet listed in *SEER Book 8*).
- hyperbaric oxygen (as an adjunct to definitive treatment)
- hyperthermia (given alone or in combination with Chemotherapy, as in isolated heated limb perfusion for melanoma)
- double-blind clinical trial information where the type of agent administered is unknown and/or there is use of a placebo (code **3**). After the code is broken, report the treatment under the appropriate modality (e.g., if the agent is revealed to be a Chemotherapy agent, code it as Chemotherapy and delete the Other Therapy code that had been applied temporarily). (To report changes to data already submitted to the MCR, call a cancer registrar at 617-624-5645).
- unorthodox and unproven treatments if these are the *only* treatment received by the patient (code **6**). These include but are not limited to: Laetrile, Krebiozen, Iscador; acupuncture/pressure; homeopathic or herbal medicine, nutritional supplements; bioelectromagnetic applications; relaxation techniques, humor therapy. If the patient receives a combination of such unorthodox treatments in addition to cancer-directed Surgery, Radiation, Chemotherapy, Hormone Therapy or Immunotherapy, then do *not* code the unorthodox treatment(s). See the *SEER Program Code Manual, 3rd Ed.* (1998), pages 140-141, for a fuller discussion.

{Do not code ancillary (non cancer-directed) drugs. These have *no coding scheme*.) You may record their use in a treatment Narrative field, but since their effects are not cancer-directed, it is not necessary to report them to the MCR.

Examples: Allopurinol, Epogen*, G-CSF (granulocyte colony stimulating factor), Leucovorin, Neupogen*

Note: This is only a partial list. Refer to the *SEER Self Instructional Manual for Tumor Registrars: Book 8, 3rd Ed.*, pages 35-46, for a more complete listing.

* Epogen and Neupogen were incorrectly listed in *Book 8* as BRM agents. SEER errata corrected these listings to the "ancillary" drug category. }

TREATMENT DATA cont.

Special Rules for Hematopoietic Diseases

For many of the hematopoietic diseases that became reportable for diagnoses made as of 2001 (such as refractory anemia), the principal treatment given may not meet the standard definition of cancer-directed therapy. SEER and the COC have agreed to record the following treatments as "Other Cancer-Directed Therapy" for hematopoietic diseases only:

- blood transfusion [of whole blood, red blood cells (RBC), platelets, fresh frozen plasma (FFP); includes cryoprecipitation, plateletpheresis]
- phlebotomy (blood removal, bloodletting, venesection)
- aspirin* [acetylsalicylic acid (ASA)]
- supportive care
- observation (watchful waiting)

* especially used to treat symptoms of essential thrombocythemia by thinning the blood; if the *reason* aspirin is given is not recorded, use the following guidelines:

if low-dose (70-100 mg/day), assume this is intended to thin the blood to help treat the disease and *record this* as Other Cancer-Directed Therapy;

if dosage is at least 160 mg/day but is not as high as the category below, assume this is for cardiovascular protection and do *not* code as cancer-directed therapy;

if higher-dose (325-1000 mg every 3-4 hours), assume this is for pain control and do *not* record as cancer-directed therapy.

Standard cancer-directed therapy for hematopoietic diseases (Radiation, Chemotherapy, Surgery) such as phosphorus-32 radiation for polycythemia vera and splenectomy for myelofibrosis should be recorded as usual in the appropriate treatment modality categories.

TREATMENT DATA cont.

Use the following codes for Other Cancer-Directed Therapy:

no Other Cancer-Directed Therapy given	0
Other Cancer-Directed Therapy, NOS	1
Other <i>experimental</i> Cancer-Directed Therapy (not included elsewhere)	2
double-blind clinical trial, code not yet broken (Code and report* the treatment actually given when the code is broken.)	3
only unproven therapy/therapies given (includes Laetrile, Krebiozen, treatment given by nonmedical personnel, etc.)	6
patient/guardian refused therapy which, if given, would have been coded as 1-3 above	7
Other Cancer-Directed Therapy recommended, but unknown if administered	8
unknown** if Other Cancer-Directed Therapy recommended or given	9

* Call us (617-624-5645) to report changes to case reports already submitted to us. Ask for a cancer registrar.

** There is reason to believe that Other Cancer-Directed Therapy was recommended or given, but there is no information to confirm this.

Other Cancer-Directed Therapy -- Summary

NAACCR Version 9.1 field "Rx Summ--Other", Item 1420, column 631

Using the table above, code Other Cancer-Directed Therapy received by the patient as part of first-course therapy. Record all procedures done at your institution and all others (if known).

Other Cancer-Directed Therapy -- At This Facility

NAACCR Version 9.1 field "Rx Hosp--Other", Item 730, column 355

Using the table above, code only Other Cancer-Directed Therapy given at your facility. Include treatment given in a staff physician's office (if available).

Other Cancer-Directed Therapy -- Date Started

NAACCR Version 9.1 field "Rx Date--Other", Item 1250, columns 577-584

See the Treatment Date instructions on page 151 and the discussion of what constitutes "Other Cancer-Directed Therapy" on pages 178-179.

Other Cancer-Directed Therapy -- Narrative

NAACCR Version 9.1 field "Rx Text--Other", Item 2670, columns 4697-4796

This field may hold up to 100 characters. See the Treatment Text instructions on page 151 and the discussion of what constitutes "Other Cancer-Directed Therapy" on pages 178-179.